# Title 27
# Insurance

**IC 27-8-5**
**Chapter 5. Accident and Sickness Insurance Policy Provisions**

**IC 27-8-5-2.5**
**Coverage of individual accident and sickness insurance policies; waivers**

Sec. 2.5. (a) As used in this section, the term "policy of accident and sickness insurance" does not include the following:
(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Automobile medical payment insurance.
(4) A specified disease policy issued as an individual policy.
(5) A limited benefit health insurance policy issued as an individual policy.
(6) A short term insurance plan that:
(A) may not be renewed; and
(B) has a duration of not more than six (6) months.
(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.
(8) Worker's compensation or similar insurance.
(9) A student health insurance policy.
(b) The benefits provided by an individual policy of accident and sickness insurance may not be excluded, limited, or denied for more than twelve (12) months after the effective date of the coverage because of a preexisting condition of the individual.
(c) An individual policy of accident and sickness insurance may not define a preexisting condition, a rider, or an endorsement more restrictively than as:
(1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve (12) months immediately preceding the effective date of enrollment in the plan;
(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve (12) months immediately preceding the effective date of enrollment in the plan; or
(3) a pregnancy existing on the effective date of enrollment in the plan.
(d) An insurer shall reduce the period allowed for a preexisting condition exclusion described in subsection (b) by the amount of time the individual has continuously served under a preexisting condition clause for a policy of accident and sickness insurance issued under IC 27-8-15 if the individual applies for a policy under this chapter not more than thirty (30) days after coverage under a policy of accident and sickness insurance issued under IC 27-8-15 expires.
(e) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. Notwithstanding subsections (b) and (c), an individual policy of accident and sickness insurance may contain a waiver of coverage for a specified condition and complications directly related to the specified condition if:
(1) the period for which the exemption would be in effect does
not exceed two (2) years; and
(2) all of the following conditions are met:
(A) The insurer provides to the applicant before issuance of the policy a written notice explaining the waiver of coverage for the specified condition and complications directly related to the specified condition, including a specific description of each condition, complication, service, and treatment for which coverage is being waived.
(B) The:
(i) offer of coverage; and
(ii) policy;
include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition and specifying each related condition, complication, service, and

treatment for which coverage is waived.
(C) The:
(i) offer of coverage; and
(ii) policy;
do not include more than two (2) waivers per individual.
(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.
(E) The insurer agrees to:
(i) review the underwriting basis for the waiver upon request one (1) time per year; and
(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.
(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage and apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.
(G) The waiver of coverage does not apply to coverage required under state law.
(H) An insurance benefit card issued by the insurer to the applicant includes a telephone number for verification of coverage waived.
The insurer shall require an applicant to initial the written notice provided under subdivision (2)(A) and the waiver included in the offer of coverage and in the policy under subdivision (2)(B) to acknowledge acceptance of the waiver of coverage. An offer of coverage under a policy that includes a waiver under this subsection does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1. This subsection expires July 1, 2007.
(f) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. An insurer shall not, on the basis of a waiver contained in a policy as provided in subsection (e), deny coverage for any condition, complication, service, or treatment that is not specified as required in the:
(1) written notice under subsection (e)(2)(A); and
(2) offer of coverage and policy under subsection (e)(2)(B).
This subsection expires July 1, 2007.
(g) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. An individual who is covered under a policy that includes a waiver under subsection (e) may directly appeal a denial of coverage based on the waiver by filing a request for an external grievance review under IC 27-8-29 without pursuing a grievance under IC 27-8-28. This subsection expires July 1, 2007.
(h) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. Notwithstanding subsection (e), an individual policy of accident and sickness insurance may not contain a waiver of coverage for:
(1) a mental health condition; or
(2) a developmental disability.
This subsection expires July 1, 2007.
(i) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. A waiver under this section may be applied to a policy of accident and sickness insurance only at the time the policy is issued. This subsection expires July 1, 2007.
(j) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. An insurer or insurance producer shall not use this section to circumvent the guaranteed access and availability provisions of this chapter, IC 27-8-15, or the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191). This subsection expires July 1, 2007.
(k) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. A pattern or practice of violations of subsections (e) through (j) is an unfair method of competition or an unfair and deceptive act and practice in the business of insurance under IC 27-4-1-4. This subsection expires July 1, 2007.
*As added by P.L.93-1995, SEC.6. Amended by P.L.190-1996, SEC.1; P.L.211-2003, SEC.2.*

**IC 27-8-5-3**
**Required provisions; statutory option provisions; inapplicable or inconsistent provisions; order of provisions; third party ownership; requirements of other jurisdictions; filing procedure**
Sec. 3. (a) Except as provided in subsection (c), each policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subsection in the words in which the same appear in this section. However, the insurer may, at its option, substitute for one (1) or more of the provisions corresponding provisions of different wording approved by the commissioner that are in each instance no

less favorable in any respect to the insured or the beneficiary. The provisions shall be preceded individually by the caption appearing in this subsection or,
at the option of the insurer, by appropriate individual or group captions or subcaptions as the commissioner may approve.
(1) A provision as follows: ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No insurance producer has authority to change this policy or to waive any of its provisions.
(2) A provision as follows: TIME LIMIT ON CERTAIN DEFENSES: (A) After two (2) years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two (2) year period.
The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy of denial of a claim during such initial two (2) year period, nor to limit the application of subsection (b), (1), (2), (3), (4), and (5) in the event of misstatement with respect to age or occupation or other insurance.
A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium:
(1) until at least age fifty (50); or
(2) in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue;
may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE": After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.
(B) No claim for loss incurred or disability (as defined in the policy) commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of coverage of this policy.
(3) A provision as follows: GRACE PERIOD: A grace period of (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.
A policy in which the insurer reserves the right to refuse renewal shall have, at the beginning of the above provision: "Unless not less than thirty (30) days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not
to renew this policy beyond the period for which the premium has been accepted.".
Each policy in which the insurer reserves the right to refuse renewal on an individual basis shall provide, in substance, in a provision of the policy, in an endorsement on the policy, or in a rider attached to the policy, that subject to the right to terminate the policy upon non-payment of premium when due, such right to refuse renewal shall not be exercised before the renewal date occurring on, or after and nearest, each anniversary, or in the case of lapse and reinstatement at the renewal date occurring on, or after and nearest, each anniversary of the last reinstatement, and that any refusal or renewal shall be without prejudice to any claim originating while the policy is in force. The preceding sentence shall not apply to accident insurance only policies.
(4) A provision as follows: REINSTATEMENT: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. Provided, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the insured and insurer shall have

the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement. The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:
(1) until at least fifty (50) years of age; or
(2) in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue.
(5) A provision as follows: NOTICE OF CLAIM: Written notice of claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the
insurer.
In a policy providing a loss-of-time benefit which may be payable for at least two (2) years, an insurer may insert the following between the first and second sentences of the above provision:
Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two (2) years, the insured shall, at least once in every six (6) months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six (6) months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insurer's right to any indemnity which would otherwise have accrued during the period of six (6) months preceding the date on which such notice is actually given.
(6) A provision as follows: CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.
(7) A provision as follows: PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.
(8) A provision as follows: TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid:
(1) immediately upon receipt of due written proof of such loss; or
(2) in accordance with IC 27-8-5.7;
whichever is more favorable to the policyholder. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid _____ (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. This provision must reflect compliance with IC 27-8-5.7.
(9) A provision as follows: PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.
The following provisions, or either of them, may be included with the foregoing provision at the option of

the insurer:
If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $ _____ (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.
Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.
For the purposes of this section a "minor" is a person under the age of eighteen (18) years. A person eighteen (18) years of age or over is competent, insofar as the person's age is concerned, to sign a valid release.
(10) A provision as follows: PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.
(11) A provision as follows: LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.
(12) A provision as follows: CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.
The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.
(13) A provision as follows: GUARANTEED RENEWABILITY: In compliance with the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191), renewability is guaranteed.
(b) Except as provided in subsection (c), no policy delivered or issued for delivery to any person in Indiana shall contain provisions respecting the matters set forth below unless the provisions are in the words in which the provisions appear in this section. However, the insurer may use, instead of any provision, a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any substitute provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by appropriate individual or group captions or subcaptions as the commissioner may approve.
(1) A provision as follows: CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed the insured's occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes the insured's occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.
(2) A provision as follows: MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct

age.
(3) A provision as follows: OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured are in force concurrently herewith, making the aggregate indemnity for _____
(insert type of coverage or coverages) in excess of $ _____ (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to the insured's estate. Or, instead of that provision: Insurance effective at any one (1) time on the insured under a like policy or policies, in this insurer is limited to the one (1) such policy elected by the insured, the insured's beneficiary or the insured's estate, as the case may be, and the insurer will return all premiums paid for all other such policies.
(4) A provision as follows: INSURANCE WITH OTHER INSURER: If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion of the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.
If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase "EXPENSE INCURRED BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".
(5) A provision as follows: INSURANCE WITH OTHER
INSURERS: If there is other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined. If the foregoing policy provision is included in a policy which also contains the next preceding policy provision, there shall be added to the caption of the foregoing provision the phrase "-OTHER BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage to the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be

included as "other valid coverage".
(6) A provision as follows: RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or the insured's average monthly earnings for the period of two (2) years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two (2) years as shall exceed the pro rata amount of the premiums for the benefits actually paid; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars ($200) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce
benefits other than those payable for loss of time.
The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:
(1) until at least fifty (50) years of age; or
(2) in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue.
The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition the term shall not include any coverage provided for the insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.
(7) A provision as follows: UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.
(8) A provision as follows: CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.
(9) A provision as follows: ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.
(10) A provision as follows: INTOXICANTS AND NARCOTICS: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.
(c) If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.
(d) The provisions which are the subject of subsections (a) and (b), or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the
consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.
(e) "Insured", as used in this chapter, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits, and rights provided therein.
(f)(1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than is

provided in this chapter and which is prescribed or required by the law of the state under which the insurer is organized.
(f)(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.
(g) The commissioner may make reasonable rules under IC 4-22-2 concerning the procedure for the filing or submission of policies subject to this chapter as are necessary, proper, or advisable to the administration of this chapter. This provision shall not abridge any other authority granted the commissioner by law.
*(Formerly: Acts 1953, c.15, s.169.3; Acts 1971, P.L.392, SEC.1; Acts 1973, P.L.275, SEC.4; Acts 1974, P.L.1, SEC.13.) As amended by P.L.28-1988, SEC.104; P.L.93-1995, SEC.8; P.L.91-1998, SEC.10; P.L.162-2001, SEC.2; P.L.178-2003, SEC.60.*

**IC 27-8-5-15.5**
Sec. 15.5. (a) As used in this section:
"Alcohol abuse" has the meaning set forth in IC 12-7-2-10.
"Community mental health center" has the meaning set forth in IC 12-7-2-38 and IC 12-7-2-39.
"Division of mental health and addiction" refers to the division created under IC 12-21-1-1.
"Drug abuse" has the meaning set forth in IC 12-7-2-72.
"Inpatient services" means services that require the beneficiary of the services to remain overnight in the facility in which the services are offered.
"Mental illness" has the meaning set forth in IC 12-7-2-130(1).
"Psychiatric hospital" has the meaning set forth in IC 12-7-2-151.
"State department of health" refers to the department established
under IC 16-19-1-1.
"Substance abuse" means drug abuse or alcohol abuse.
(b) An insurance policy that provides coverage for inpatient services for the treatment of:
(1) mental illness;
(2) substance abuse; or
(3) both mental illness and substance abuse;
may not exclude coverage for inpatient services for the treatment of mental illness or substance abuse that are provided by a community mental health center or by any psychiatric hospital licensed by the state department of health or the division of mental health and addiction to offer those services.
*As added by P.L.258-1985, SEC.1. Amended by P.L.2-1992, SEC.784; P.L.2-1993, SEC.150; P.L.215-2001, SEC.104*
**IC 27-8-5-15.6**
**Treatment limitations or financial requirements on coverage of services for mental illness**
Sec. 15.6. (a) As used in this section, "coverage of services for a mental illness" includes the services defined under the policy of accident and sickness insurance. However, the term does not include services for the treatment of substance abuse or chemical dependency.
(b) This section applies to a policy of accident and sickness insurance that:
(1) is issued on an individual basis or a group basis;
(2) is issued, entered into, or renewed after December 31, 1999; and
(3) is issued to an employer that employs more than fifty (50) full-time employees.
(c) This section does not apply to the following:
(1) An insurance policy listed under IC 27-8-15-9(b).
(2) A legal business entity that has obtained an exemption under section 15.7 of this chapter.
(d) A group or individual insurance policy or agreement may not permit treatment limitations or financial requirements on the coverage of services for a mental illness if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.
(e) An insurer that issues a policy of accident and sickness insurance that provides coverage of services for the treatment of substance abuse and chemical dependency when the services are required in the treatment of a mental illness shall offer to provide the coverage without treatment limitations or financial requirements if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.
(f) This section does not require a group or individual insurance policy or agreement to offer mental health benefits.

(g) The benefits delivered under this section may be delivered under a managed care system.
*As added by P.L.42-1997, SEC.2. Amended by P.L.81-1999, SEC.3; P.L.226-2003, SEC.1.*

**IC 27-8-5-16.5**
**Conditions for issuance of certificate to resident of Indiana under group policy delivered or issued in another state**
Sec. 16.5. (a) As used in this section, "delivery state" means any state other than Indiana in which a policy is delivered or issued for delivery.
(b) Except as provided in subsection (c), (d), or (e), a certificate may not be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana.
(c) A certificate may be issued to a resident of Indiana pursuant to a group policy not described in subsection (d) that is delivered or issued for delivery in a state other than Indiana if:
(1) the delivery state has a law substantially similar to section 16 of this chapter;
(2) the delivery state has approved the group policy; and
(3) the policy or the certificate contains provisions that are:
(A) substantially similar to the provisions required by:
(i) section 19 of this chapter;
(ii) section 21 of this chapter; and
(iii) IC 27-8-5.6; and
(B) consistent with the requirements set forth in:
(i) section 24 of this chapter;
(ii) IC 27-8-6;
(iii) IC 27-8-14;
(iv) IC 27-8-23;
(v) 760 IAC 1-38.1; and
(vi) 760 IAC 1-39.
(d) A certificate may be issued to a resident of Indiana under an association group policy, a discretionary group policy, or a trust group policy that is delivered or issued for delivery in a state other than Indiana if:
(1) the delivery state has a law substantially similar to section 16 of this chapter;
(2) the delivery state has approved the group policy; and
(3) the policy or the certificate contains provisions that are:
(A) substantially similar to the provisions required by:
(i) section 19 of this chapter;
(ii) section 19.2 of this chapter if the policy or certificate contains a waiver of coverage;
(iii) section 21 of this chapter; and
(iv) IC 27-8-5.6; and
(B) consistent with the requirements set forth in:
(i) section 15.6 of this chapter;
(ii) section 24 of this chapter;
(iii) section 26 of this chapter;
(iv) IC 27-8-6;
(v) IC 27-8-14;
(vi) IC 27-8-14.1;
(vii) IC 27-8-14.5;
(viii) IC 27-8-14.7;
(ix) IC 27-8-14.8;
(x) IC 27-8-20;
(xi) IC 27-8-23;
(xii) IC 27-8-24.3;
(xiii) IC 27-8-26;
(xiv) IC 27-8-28;
(xv) IC 27-8-29;
(xvi) 760 IAC 1-38.1; and
(xvii) 760 IAC 1-39.
(e) A certificate may be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana if the commissioner determines that the policy pursuant to which

the certificate is issued meets the requirements set forth in section 17(a) of this chapter.
(f) This section does not affect any other provision of Indiana law governing the terms or benefits of coverage provided to a resident of Indiana under any certificate or policy of insurance.
*As added by P.L.185-1996, SEC.12. Amended by P.L.96-2002, SEC.1; P.L.211-2003, SEC.3.*

**IC 27-8-5-19.2**
**Association group and discretionary group accident and sickness insurance policies; waivers**
Sec. 19.2. (a) This section applies to an association or a discretionary group policy of accident and sickness insurance:
(1) under which a certificate of coverage is issued after June 30, 2003, and before July 1, 2005, by the insurers selected under subsection (c) to an individual member of the association or discretionary group;
(2) under which a member of the association or discretionary group is individually underwritten; and
(3) that is not employer based.
(b) Notwithstanding section 19 of this chapter, the commissioner appointed under IC 27-1-1-2 shall, not later than July 1, 2003, establish a two (2) year demonstration project to evaluate the value of preexisting condition exclusion waivers to consumers of policies described in subsection (a). The demonstration project established under this subsection must allow the insurers selected under subsection (c) to issue a policy described in subsection (a) that contains a waiver of coverage described in subsection (e) only if the requirements of this section are met.
(c) The commissioner shall select three (3) insurers (as defined in IC 27-1-2-3) that meet the following requirements to participate in the demonstration project described in subsection (b):
(1) The insurer has previously offered in Indiana an individually underwritten policy described in subsection (a) with a preexisting condition exclusion waiver.
(2) The insurer has a previously documented program for administering a policy described in subdivision (1) that includes consumer safeguards to:
(A) provide prior written notice of conditions subject to the waiver;
(B) limit the number of waivers per individual;
(C) limit the period during which a waiver may be in effect; and
(D) provide for full benefits upon the expiration of the waiver.
(d) The insurers selected under subsection (c):
(1) may each issue not more than one thousand five hundred (1,500) certificates of coverage containing a waiver under this section; and
(2) shall bear all costs of the demonstration project established under this section, including any research, analysis, and reporting related to the demonstration project.
(e) Notwithstanding section 19 of this chapter, a policy described in subsection (a) may contain a waiver of coverage for a specified condition and complications directly related to the specified condition if:
(1) the period for which the exemption would be in effect does not exceed two (2) years; and
(2) all of the following conditions are met:
(A) The insurer provides to the applicant before issuance of the policy a written notice explaining the waiver of coverage for the specified condition and complications directly related to the specified condition, including a specific description of each condition, complication, service, and treatment for which coverage is being waived.
(B) The:
(i) offer of coverage; and
(ii) certificate of coverage;
include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition and specifying each related condition, complication, service, and treatment for which coverage is waived.
(C) The:
(i) offer of coverage; and
(ii) certificate of coverage;
do not include more than two (2) waivers per individual.
(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.
(E) The insurer agrees to:

(i) review the underwriting basis for the waiver upon request one (1) time per year; and
(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.
(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage, and any individual to whom the waiver would have applied may apply for a policy issued by the Indiana comprehensive health insurance
association under IC 27-8-10.
(G) The waiver of coverage does not apply to coverage required under state law.
(H) An insurance benefit card issued by the insurer to the applicant includes a telephone number for verification of coverage waived.
(f) The insurer shall require an applicant to initial the written notice provided under subsection (e)(2)(A) and the waiver included in the offer of coverage and in the certificate of coverage under subsection (e)(2)(B) to acknowledge acceptance of the waiver of coverage.
(g) An insurer shall not, on the basis of a waiver contained in a policy as provided in this section, deny coverage for any condition, complication, service, or treatment that is not specified as required in the:
(1) written notice under subsection (e)(2)(A); and
(2) offer of coverage and certificate of coverage under subsection (e)(2)(B).
(h) An individual who is covered under a policy that includes a waiver under this section may directly appeal a denial of coverage based on the waiver by filing a request for an external grievance review under IC 27-8-29 without pursuing a grievance under IC 27-8-28.
(i) An offer of coverage under a policy that includes a waiver under this section does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1.
(j) Notwithstanding subsection (e), a policy described in subsection (a) may not contain a waiver of coverage for:
(1) a mental health condition; or
(2) a developmental disability.
(k) A waiver under this section may be applied to a certificate of coverage of accident and sickness insurance only at the time the certificate is issued.
(l) An insurer or insurance producer shall not use this section to circumvent the guaranteed access and availability provisions of this chapter, IC 27-8-15, or the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).
(m) A pattern or practice of violations of this section is an unfair method of competition or an unfair and deceptive act and practice in the business of insurance under IC 27-4-1-4.
(n) This section expires July 1, 2007.
*As added by P.L.211-2003, SEC.4.*

**IC 27-8-5-26**
**Post-mastectomy coverage**
Sec. 26. (a) As used in this section, "mastectomy" means the removal of all or part of the breast for reasons that are determined by a licensed physician to be medically necessary.
(b) A policy of accident and sickness insurance that provides coverage for a mastectomy may not be issued, amended, delivered, or renewed in Indiana unless the policy provides coverage as required under 29 U.S.C. 1185b, including coverage for:
(1) prosthetic devices; and
(2) reconstructive surgery incident to a mastectomy including:
(A) all stages of reconstruction of the breast on which the mastectomy has been performed; and
(B) surgery and reconstruction of the other breast to produce symmetry;
in the manner determined by the attending physician and the patient to be appropriate.
(c) Coverage required under this section is subject to:
(1) the deductible and coinsurance provisions applicable to a mastectomy; and
(2) all other terms and conditions applicable to other benefits.
(d) An insurer that issues a policy of accident and sickness insurance shall provide to an insured, at the time the policy is issued and annually thereafter, written notice of the coverage required under this section. Notice that is sent by the insurer that meets the requirements set forth in 29 U.S.C. 1185b constitutes compliance with this subsection.
(e) The coverage required under this section applies to a policy of accident and sickness insurance that provides coverage for a

mastectomy, regardless of whether an individual who:
(1) underwent a mastectomy; and
(2) is covered under the policy;
was covered under the policy at the time of the mastectomy.
(f) This section does not require an insurer to provide coverage related to post mastectomy care that exceeds the coverage required for post mastectomy care under federal law.
*As added by P.L.150-1997, SEC.3. Amended by P.L.96-2002, SEC.2; P.L.204-2003, SEC.1*

## ARTICLE 13. HEALTH MAINTENANCE ORGANIZATIONS

**IC 27-8-13-2**
**"Medicare supplement insurance solicitation" defined**
Sec. 2. As used in this chapter, "Medicare supplement insurance solicitation" means a meeting between an insurance producer and another individual at which the insurance producer discusses the possible issuance of a medicare supplement policy to the other individual.
*As added by P.L.275-1987, SEC.2. Amended by P.L.178-2003, SEC.69.*

**IC 27-8-13-4**
**Receipt for materials received by soliciting insurance producer; "materials"**
Sec. 4. (a) Following a Medicare supplement insurance solicitation, an insurance producer shall give the individual involved in the solicitation a receipt for materials received by the insurance producer as a result of the solicitation.
(b) The receipt required under subsection (a) must be dated and
signed by the insurance producer and must set forth the following:
(1) An itemized list of the materials received by the insurance producer.
(2) The insurance producer's name.
(3) The address and telephone number of the insurance producer's office.
(c) As used in this section, "materials" includes any:
(1) document;
(2) cash;
(3) money order; or
(4) check or draft;
received by the insurance producer. The term does not include an application for a policy.
*As added by P.L.275-1987, SEC.2. Amended by P.L.178-2003, SEC.70.*

**IC 27-13-7**
**Chapter 7. Requirements for Group Contracts, Individual Contracts, and Evidence of Coverage**

**IC 27-13-7-14**
**Post-mastectomy coverage**
Sec. 14. (a) As used in this section, "mastectomy" means the removal of all or part of the breast for reasons that are determined by a licensed physician to be medically necessary.
(b) A contract with a health maintenance organization that provides coverage for a mastectomy must provide coverage as required under 29 U.S.C. 1185b, including coverage for:
(1) prosthetic devices; and
(2) reconstructive surgery incident to a mastectomy including:
(A) all stages of reconstruction of the breast on which the mastectomy has been performed; and
(B) surgery and reconstruction of the other breast to produce symmetry;
in the manner determined by the attending physician and the patient to be appropriate.
(c) Coverage required under this section is subject to:
(1) the deductible and coinsurance provisions applicable to a mastectomy; and
(2) all other terms and conditions applicable to other services under the contract.
(d) A health maintenance organization shall provide to an enrollee, at the time that an individual contract or a group contract is entered into and annually thereafter, written notice of the coverage required under this

section. Notice that is sent by the health maintenance organization that meets the requirements set forth in 29 U.S.C. 1185b constitutes compliance with this subsection.
(e) The coverage required under this section applies to a contract with a health maintenance organization that provides coverage for a mastectomy, regardless of whether an individual who:
(1) underwent a mastectomy; and
(2) is covered under the contract;
was covered under the contract at the time of the mastectomy.
(f) This section does not require a health maintenance organization to provide coverage related to post mastectomy care that exceeds the coverage required for post mastectomy care under federal law.
*As added by P.L.150-1997, SEC.5. Amended by P.L.2-1998, SEC.71; P.L.96-2002, SEC.3; P.L.204-2003, SEC.2.*

**IC 27-13-7-14.8**
**Treatment limitations or financial requirements on coverage of services for mental illness**
Sec. 14.8. (a) As used in this section, "coverage of services for a mental illness" includes the services defined under the contract with the health maintenance organization. However, the term does not include services for the treatment of substance abuse or chemical dependency.
(b) This section applies to a group or individual contract with a health maintenance organization that:
(1) is issued, entered into, or renewed after December 31, 1999; and
(2) is issued to an employer that employs more than fifty (50) full-time employees.
(c) This section does not apply to a legal business entity that has obtained an exemption under IC 27-8-5-15.7.
(d) A group or individual contract with a health maintenance organization may not permit treatment limitations or financial requirements on the coverage of services for a mental illness if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.
(e) A health maintenance organization that enters into an individual contract or a group contract that provides coverage of services for the treatment of substance abuse and chemical dependency when the services are required in the treatment of a mental illness shall offer to provide the coverage without treatment limitations or financial requirements if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.
(f) This section does not require a group or individual contract with a health maintenance organization to offer mental health benefits.
*As added by P.L.42-1997, SEC.3. Amended by P.L.81-1999, SEC.5; P.L.226-2003, SEC.2.*

**IC 27-13-7-18**
**Inherited metabolic disease coverage**
***Effective 1-1-2004.***
Sec. 18. (a) As used in this section, "inherited metabolic disease" means a disease:
(1) caused by inborn errors of amino acid, organic acid, or urea cycle metabolism; and
(2) treatable by the dietary restriction of one (1) or more amino acids.
(b) As used in this section, "medical food" means a formula that is:
(1) intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and
(2) formulated to be consumed or administered enterally under the direction of a physician.
(c) A group health maintenance organization contract that provides coverage for basic health care services must provide coverage for medical food that is:
(1) medically necessary; and
(2) prescribed for an enrollee by the enrollee's treating physician for treatment of the enrollee's inherited metabolic disease.
(d) The coverage that must be provided under this section shall not be subject to dollar limits, copayments, or deductibles that are less favorable to an enrollee than the dollar limits, copayments, or deductibles that apply to coverage for:
(1) prescription drugs generally under the group contract, if prescription drugs are covered under the group contract; or
(2) physical illness generally under the group contract, if prescription drugs are not covered under the group contract.
*As added by P.L.166-2003, SEC.3.*